STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155757	A. BUILDING _____ B. WING _____	02/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEGATE VILLAGE LLC	7510 ROSEGATE DR INDIANAPOLIS, IN46237

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: February 21-25, 2011 Facility number: 011149 Provider number: 155757 AIM number: 200829340 Survey team: Teresa Buske RN/TC Mary Weyls RN Laura Brashear RN Census bed type: SNF: 38 SNF/NF: 107 Total: 145 Census payor type: Medicare: 41 Medicaid: 84 Other: 20 Total: 145 Sample: 24 Supplemental sample: 5 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 3/02/11 by Suzanne	F0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567L Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Review on or after March 27, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Williams, RN			

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F0221 SS=D	Based on observation, interview, and record review, the facility failed to assess and attempt restraint reduction for 1 of 2 residents reviewed in a sample of 24 utilizing physical restraints [Resident #52]. Finding includes: During initial tour on 2/21/11, which began at 11:15 a.m., with RN #19, Resident #52 was identified as utilizing a self release alarmed seat belt in the wheelchair. RN #19 indicated the resident had no recent falls. On 2/23/11 at 4:40 p.m., during the supper meal, Resident #52 was observed in the dining room, seated in a wheelchair with the seat belt on. A family member was observed seated with the resident.	F0221	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · A 30 day restraint review has been completed for resident #52. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have been identified that are currently coded for the use of a restraint. · All residents identified have had a 30 day restraint review form completed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The ongoing use of a physical restraint will be reviewed every 30 days by the interdisciplinary team, and the monthly restraint review form will be completed. · All residents that are currently coded for the use of restraints will be scheduled for IDT review every 30 days after initiation of restraint per policy. · In-services will be held to train the interdisciplinary team on the use and importance of the 30 day restraint review. **How the corrective action (s)will be monitored to ensure the deficient practice will not recur, i.e., what quality**	03/27/2011

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	On 2/24/11 at 12:05 p.m., while seated in the wheelchair by the nurses' station, Resident #52 was able to release the seat belt upon command. Resident #52's clinical record was reviewed on 2/25/11 at 11:25 a.m. The resident's diagnoses included, but was not limited to, delirium and dementia. A physician's order was noted dated 2/17/10 for self release belt at all times in wheelchair. A quarterly MDS [Minimum Data Set] assessment, completed on 1/12/11 coded the resident with no falls, and utilized a trunk restraint. A plan of care with original date of 10/25/10, addressed the		**assurance program will be put into place?** · A CQI audit tool will be utilized by DNS/designee to monitor compliance of the 30 day restraint review form weekly X 4 weeks, monthly X 2 months and quarterly thereafter. · Results of these evaluation processes will be presented to the CQI Committee monthly to review for compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action.	

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	problem of "Needs SELF RELEASING ALARMING BELT restraints to prevent injury due to POOR SAFETY AWARENESS, IMPAIRED COGNITION." Interventions with estimated date of 4/13/11 included, but were not limited to, Restraint when up in wheelchair, check every hour, release every 2 hours, evaluate at least every three months for less restrictive measures, and IDT [Interdisciplinary team] to review for least restrictive device per policy. An Interdisciplinary Team Progress Note, dated 10/19/10 documented: IDT met to review residents [sic] restraints. Res [resident] continues to utilize self release wc [wheelchair] belt @ [at] all times when up in wc d/t [due			

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	to] poor safety awareness. Res has hx of falls and DX [diagnosis] of Dementia. Res. can release belt but not always on command. No s/s [signs, symptoms] of distress related to self release seat belt. Res. currently on walk to dine program . ...IDT feels @ this time the self release wc seat belt is indicated d/t over estimated her abilities to stand and transfer self...." The facility's policy titled "Physical restraints" dated 3/10, provided by the DON on 2/25/11 at 3:45 p.m. included, but was not limited to: "...Restraint use will be considered only after less restrictive measures have failed, and the interdisciplinary team determines that they are needed to treat resident (s)			

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	medical symptoms. ...11. The ongoing use of a physical restraint will be reviewed every 30 days by the interdisciplinary team, and the monthly restraint review form will be completed. 12. The "monthly restraint review" form will indicate any reduction attempts and rationale for continued use." The DON was interviewed on 2/25/11 at 3:20 p.m. The DON indicated there was no documentation of any attempts to reduce the restraint in the last six months, and could not ensure that attempts of reduction had been done. 3.1-3(w) 3.1-26(o)			

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F0286 SS=E	Based on interview and record review, the facility failed to maintain complete 3.0 Minimum Data Set Assessments of 17 of 20 residents reviewed in an sample of 24, required to have a Minimum Data Set Assessment, in that completed 3.0 Minimum Data Set assessments were not maintained on the residents' clinical records, or accessible to all professional staff members. [Residents #1, #4, #15, #16, #17, #119, #86, #127, #133, #112, #97, # 33, # 87, #49, #36, #45, #39] Findings include: 1. On 2/21/11 at 2:30 p.m., Resident #1's clinical record was reviewed. A 3.0 Minimum Data Set Assessment,	F0286	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #1's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #4's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #15's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #16's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #17's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #119's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data	03/27/2011

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	completed on 12/22/10 was not on the resident's clinical record, or accessible to professional staff. Section A [Identification Information], Section V [Care Area Assessment (CAA) Summary, and Section Z [Assessment Administration] were on the clinical record. Sections B [Hearing, Speech, and Vision,] Section C [Cognitive Patterns], Section D [Mood], Section E [Behavior], Section F [Preferences for Customary Routine and Activities], Section G [Functional Status], Section H [Bladder and Bowel], Section I [Active Diagnoses], Section J [Health Conditions], Section K [Swallowing/Nutritional Status], Section L [Oral/Dental		Set Assessments were immediately printed and placed on Resident #86's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #127's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #133's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #112's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #97's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #33's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #87's clinical record and made accessible to all professional staff members.	

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	Status] Section M [Skin Conditions], Section N [Medications], Section O [Special Treatments, Procedures, and Programs,] Section P [Restraints], Section Q [Participation in Assessment and Goal Setting], were not on the clinical record. The Administrator was interviewed on 2/21/11 at 3:00 p.m. The Administrator indicated the completed assessment was not maintained on the chart, or accessible to all professional staff. 2. On 2/24/11 at 3:35 p.m., Resident #4's clinical record was reviewed. A 3.0 Minimum Data Set Assessment, completed on 2/14/11 was on the record.		· Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #49's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #36's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #45's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #39's clinical record and made accessible to all professional staff members. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on all residents' clinical records and made accessible to all professional staff members. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Facility has eliminated the use	

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	The Administrator was interviewed on 2/22/11 at 9:45 a.m. The Administrator indicated the completed assessments had not been maintained on the chart prior to the day before when all assessments were printed and placed on the clinical records by the facility choice. The Administrator indicated Section A [Identification Information], Section V [Care Area Assessment (CAA) Summary, and Section Z [Assessment Administration] had been placed on the clinical record but Sections B [Hearing, Speech, and Vision,] Section C [Cognitive Patterns], Section D [Mood], Section E [Behavior], Section F [Preferences for Customary Routine and Activities], Section G		of the Electronic Storage of MDS (Minimum Data Set) policy. · Facility practice has been revised so that completed 3.0 Minimum Data Set Assessments will be printed and placed on all residents' clinical records and made accessible to all professional staff members. · MDS staff and other professional staff will be educated on the revised facility practice. **How the corrective action (s)will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A CQI tool will be utilized by MDS Coordinator/designee to monitor compliance with printing and making accessible completed 3.0 MinimumData Set Assessments weekly x 4 weeks, monthly x2 months and quarterly thereafter. · Results of the audit will be presented to the CQI Committee monthly to ensure compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action.	

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	[Functional Status], Section H [Bladder and Bowel], Section I [Active Diagnoses], Section J [Health Conditions], Section K [Swallowing/Nutritional Status], Section L [Oral/Dental Status] Section M [Skin Conditions], Section N [Medications], Section O [Special Treatments, Procedures, and Programs,] Section P [Restraints], Section Q [Participation in Assessment and Goal Setting], had not until after discussion with surveyors. 3. On 2/24/11 at 4:30 p.m., Resident #15's clinical record was reviewed. A 3.0 Minimum Data Set Assessment, completed on 2/16/11 was on the record. The Administrator was interviewed on 2/22/11 at 9:45			

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	a.m. The Administrator indicated the completed assessments had not been maintained on the chart prior to the day before when all assessments were printed and placed on the clinical records by the facility choice. The Administrator indicated Section A [Identification Information], Section V [Care Area Assessment (CAA) Summary, and Section Z [Assessment Administration] had been placed on the clinical record but Sections B [Hearing, Speech, and Vision,] Section C [Cognitive Patterns], Section D [Mood], Section E [Behavior], Section F [Preferences for Customary Routine and Activities], Section G [Functional Status], Section H [Bladder and Bowel], Section I			

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	[Active Diagnoses], Section J [Health Conditions], Section K [Swallowing/Nutritional Status], Section L [Oral/Dental Status] Section M [Skin Conditions], Section N [Medications], Section O [Special Treatments, Procedures, and Programs,] Section P [Restraints], Section Q [Participation in Assessment and Goal Setting], had not until after discussion with surveyors. 4. On 2/25/11 at 10:50 a.m., Resident #16's clinical record was reviewed. A 3.0 Minimum Data Set Assessment, completed on 1/28/11 was on the record. The Administrator was interviewed on 2/22/11 at 9:45 a.m. The Administrator indicated the completed			

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	assessments had not been maintained on the chart prior to the day before when all assessments were printed and placed on the clinical records by the facility choice. The Administrator indicated Section A [Identification Information], Section V [Care Area Assessment (CAA) Summary, and Section Z [Assessment Administration] had been placed on the clinical record but Sections B [Hearing, Speech, and Vision,] Section C [Cognitive Patterns], Section D [Mood], Section E [Behavior], Section F [Preferences for Customary Routine and Activities], Section G [Functional Status], Section H [Bladder and Bowel], Section I [Active Diagnoses], Section J [Health Conditions], Section K			

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	[Swallowing/Nutritional Status], Section L [Oral/Dental Status] Section M [Skin Conditions], Section N [Medications], Section O [Special Treatments, Procedures, and Programs,] Section P [Restraints], Section Q [Participation in Assessment and Goal Setting], had not until after discussion with surveyors. 5. On 2/25/11 at 11:50 p.m., Resident #17's clinical record was reviewed. A 3.0 Minimum Data Set Assessment, completed on 2/10/11 was on the record. The Administrator was interviewed on 2/22/11 at 9:45 a.m. The Administrator indicated the completed assessments had not been maintained on the chart prior to			

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	the day before when all assessments were printed and placed on the clinical records by the facility choice. The Administrator indicated Section A [Identification Information], Section V [Care Area Assessment (CAA) Summary, and Section Z [Assessment Administration] had been placed on the clinical record but Sections B [Hearing, Speech, and Vision,] Section C [Cognitive Patterns], Section D [Mood], Section E [Behavior], Section F [Preferences for Customary Routine and Activities], Section G [Functional Status], Section H [Bladder and Bowel], Section I [Active Diagnoses], Section J [Health Conditions], Section K [Swallowing/Nutritional Status], Section L [Oral/Dental			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Status] Section M [Skin Conditions], Section N [Medications], Section O [Special Treatments, Procedures, and Programs,] Section P [Restraints], Section Q [Participation in Assessment and Goal Setting], had not until after discussion with surveyors.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155757	A. BUILDING _____ B. WING _____	02/25/2011

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F0286 SS=E	6. Resident #97's clinical record was reviewed on 2/21/11 at 1:45 p.m. An admission date of 10/26/10 was noted. Section A [Identification Information], and Section Z [Assessment Administration] were on the clinical record. Sections B [Hearing, Speech, and Vision,] Section C [Cognitive Patterns], Section D [Mood], Section E [Behavior], Section F [Preferences for Customary Routine and Activities], Section G [Functional Status], Section H [Bladder and Bowel], Section I [Active Diagnoses], Section J [Health Conditions], Section K [Swallowing/Nutritional Status], Section L [Oral/Dental Status] Section M [Skin Conditions], Section N [Medications], Section O	F0286	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #1's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #4's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #15's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #16's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #17's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #119's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data	03/27/2011

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	[Special Treatments, Procedures, and Programs,] Section P [Restraints], Section Q [Participation in Assessment and Goal Setting], were not on the clinical record. The Administrator was interviewed on 2/21/11 at 3:00 p.m. The Administrator indicated the completed assessment was not maintained on the chart, or accessible to all professional staff. During interview of the Director of Nursing on 2/21/11 at 3 p.m., the DON indicated the assessments were computerized. The DON indicated the only staff with access to the assessments were the staff that entered the information into the computer. The DON also indicated the 2.0 assessments, after October 2010 were pulled from the resident's clinical record and placed into overflow. 7. Resident #112's clinical record was reviewed on 2/22/11 at 2:55 p.m. A significant change assessment was noted, dated 5/31/10, and a quarterly assessment was noted, dated 11/24/10.		Set Assessments were immediately printed and placed on Resident #86's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #127's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #133's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #112's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #97's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #33's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #87's clinical record and made accessible to all professional staff members.	

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	The Administrator was interviewed on 2/22/11 at 9:45 a.m. The Administrator indicated the completed assessments had not been maintained on the chart prior to the day before when all assessments were printed and placed on the clinical records by the facility choice. The Administrator indicated Section A [Identification Information], Section V [Care Area Assessment (CAA) Summary, and Section Z [Assessment Administration] had been placed on the clinical record but Sections B [Hearing, Speech, and Vision,] Section C [Cognitive Patterns], Section D [Mood], Section E [Behavior], Section F [Preferences for Customary Routine and		· Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #49's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #36's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #45's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #39's clinical record and made accessible to all professional staff members. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on all residents' clinical records and made accessible to all professional staff members. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Facility has eliminated the use	

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	Activities], Section G [Functional Status], Section H [Bladder and Bowel], Section I [Active Diagnoses], Section J [Health Conditions], Section K [Swallowing/Nutritional Status], Section L [Oral/Dental Status] Section M [Skin Conditions], Section N [Medications], Section O [Special Treatments, Procedures, and Programs,] Section P [Restraints], Section Q [Participation in Assessment and Goal Setting], had not until after discussion with surveyors. 8. Resident #133's clinical record was reviewed on 2/23/11 at 1:15 p.m. A 2.0 annual assessment was noted, dated 5/13/11 and a quarterly 3.0 assessment was noted, dated 1/24/11.		of the Electronic Storage of MDS (Minimum Data Set) policy. · Facility practice has been revised so that completed 3.0 Minimum Data Set Assessments will be printed and placed on all residents' clinical records and made accessible to all professional staff members. · MDS staff and other professional staff will be educated on the revised facility practice. **How the corrective action (s)will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A CQI tool will be utilized by MDS Coordinator/designee to monitor compliance with printing and making accessible completed 3.0 MinimumData Set Assessments weekly x 4 weeks, monthly x2 months and quarterly thereafter. · Results of the audit will be presented to the CQI Committee monthly to ensure compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action.	

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	The Administrator was interviewed on 2/22/11 at 9:45 a.m. The Administrator indicated the completed assessments had not been maintained on the chart prior to the day before when all assessments were printed and placed on the clinical records by the facility choice. The Administrator indicated Section A [Identification Information], Section V [Care Area Assessment (CAA) Summary, and Section Z [Assessment Administration] had been placed on the clinical record but Sections B [Hearing, Speech, and Vision,] Section C [Cognitive Patterns], Section D [Mood], Section E [Behavior], Section F [Preferences for Customary Routine and			

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	Activities], Section G [Functional Status], Section H [Bladder and Bowel], Section I [Active Diagnoses], Section J [Health Conditions], Section K [Swallowing/Nutritional Status], Section L [Oral/Dental Status] Section M [Skin Conditions], Section N [Medications], Section O [Special Treatments, Procedures, and Programs,] Section P [Restraints], Section Q [Participation in Assessment and Goal Setting], had not until after discussion with surveyors. 9. Resident #127's clinical record was reviewed on 2/24/11 at 11:25 a.m. A significant change assessment was noted, dated 12/20/10.			

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	The Administrator was interviewed on 2/22/11 at 9:45 a.m. The Administrator indicated the completed assessments had not been maintained on the chart prior to the day before when all assessments were printed and placed on the clinical records by the facility choice. The Administrator indicated Section A [Identification Information], Section V [Care Area Assessment (CAA) Summary, and Section Z [Assessment Administration] had been placed on the clinical record but Sections B [Hearing, Speech, and Vision,] Section C [Cognitive Patterns], Section D [Mood], Section E [Behavior], Section F [Preferences for Customary Routine and Activities], Section G			

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	[Functional Status], Section H [Bladder and Bowel], Section I [Active Diagnoses], Section J [Health Conditions], Section K [Swallowing/Nutritional Status], Section L [Oral/Dental Status] Section M [Skin Conditions], Section N [Medications], Section O [Special Treatments, Procedures, and Programs,] Section P [Restraints], Section Q [Participation in Assessment and Goal Setting], had not until after discussion with surveyors. 10. Resident #86's clinical record was reviewed on 2/24/11 at 2:40 p.m. An annual assessment, dated 6/27/10 and a quarterly assessment dated December 2010 was noted.			

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	The Administrator was interviewed on 2/22/11 at 9:45 a.m. The Administrator indicated the completed assessments had not been maintained on the chart prior to the day before when all assessments were printed and placed on the clinical records by the facility choice. The Administrator indicated Section A [Identification Information], Section V [Care Area Assessment (CAA) Summary, and Section Z [Assessment Administration] had been placed on the clinical record but Sections B [Hearing, Speech, and Vision,] Section C [Cognitive Patterns], Section D [Mood], Section E [Behavior], Section F [Preferences for Customary Routine and Activities], Section G			

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	[Functional Status], Section H [Bladder and Bowel], Section I [Active Diagnoses], Section J [Health Conditions], Section K [Swallowing/Nutritional Status], Section L [Oral/Dental Status] Section M [Skin Conditions], Section N [Medications], Section O [Special Treatments, Procedures, and Programs,] Section P [Restraints], Section Q [Participation in Assessment and Goal Setting], had not until after discussion with surveyors. 11. Resident #119's clinical record was reviewed on 2/24/11 at 4:34 p.m. A significant change assessment, dated 9/17/10, and a quarterly assessment, dated 12/13/10.			

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	The Administrator was interviewed on 2/22/11 at 9:45 a.m. The Administrator indicated the completed assessments had not been maintained on the chart prior to the day before when all assessments were printed and placed on the clinical records by the facility choice. The Administrator indicated Section A [Identification Information], Section V [Care Area Assessment (CAA) Summary, and Section Z [Assessment Administration] had been placed on the clinical record but Sections B [Hearing, Speech, and Vision,] Section C [Cognitive Patterns], Section D [Mood], Section E [Behavior], Section F [Preferences for Customary Routine and Activities], Section G			

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	[Functional Status], Section H [Bladder and Bowel], Section I [Active Diagnoses], Section J [Health Conditions], Section K [Swallowing/Nutritional Status], Section L [Oral/Dental Status] Section M [Skin Conditions], Section N [Medications], Section O [Special Treatments, Procedures, and Programs,] Section P [Restraints], Section Q [Participation in Assessment and Goal Setting], had not until after discussion with surveyors.			

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F0286 SS=E	12. On 2/21/11 at 1:45 p.m., Resident #87's clinical record was reviewed. A 3.0 Minimum Data Set Assessment, completed on 12/15/10, was not on the resident's clinical record, or accessible to professional staff. Section A [Identification Information], Section V [Care Area Assessment (CAA) Summary, and Section Z [Assessment Administration] were on the clinical record. Sections B [Hearing, Speech, and Vision,] Section C [Cognitive Patterns], Section D [Mood], Section E [Behavior], Section F [Preferences for Customary Routine and Activities], Section G [Functional Status], Section H [Bladder and Bowel], Section I	F0286	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #1's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #4's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #15's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #16's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #17's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #119's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data	03/27/2011

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	[Active Diagnoses], Section J [Health Conditions], Section K [Swallowing/Nutritional Status], Section L [Oral/Dental Status] Section M [Skin Conditions], Section N [Medications], Section O [Special Treatments, Procedures, and Programs,] Section P [Restraints], Section Q [Participation in Assessment and Goal Setting], were not on the clinical record. The Administrator was interviewed on 2/21/11 at 3:00 p.m. The Administrator indicated the completed assessment was not maintained on the chart, or accessible to all professional staff. 13. On 2/22/11 at 3:00 p.m., Resident #33's clinical record was reviewed. A 3.0 Minimum		Set Assessments were immediately printed and placed on Resident #86's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #127's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #133's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #112's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #97's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #33's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #87's clinical record and made accessible to all professional staff members.	

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	Data Set Assessment, completed on 1/27/11, was on the record. The Administrator was interviewed on 2/22/11 at 9:45 a.m. The Administrator indicated the completed assessments had not been maintained on the chart prior to the day before when all assessments were printed and placed on the clinical records by facility choice. The Administrator indicated Section A [Identification Information], Section V [Care Area Assessment (CAA) Summary, and Section Z [Assessment Administration] had been placed on the clinical record but Sections B [Hearing, Speech, and Vision,] Section C [Cognitive Patterns], Section D		· Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #49's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #36's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #45's clinical record and made accessible to all professional staff members. · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on Resident #39's clinical record and made accessible to all professional staff members. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · Completed 3.0 Minimum Data Set Assessments were immediately printed and placed on all residents' clinical records and made accessible to all professional staff members. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Facility has eliminated the use	

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	[Mood], Section E [Behavior], Section F [Preferences for Customary Routine and Activities], Section G [Functional Status], Section H [Bladder and Bowel], Section I [Active Diagnoses], Section J [Health Conditions], Section K [Swallowing/Nutritional Status], Section L [Oral/Dental Status] Section M [Skin Conditions], Section N [Medications], Section O [Special Treatments, Procedures, and Programs,] Section P [Restraints], Section Q [Participation in Assessment and Goal Setting], had not until after discussion with surveyors. 14. On 2/24/11 at 11:20 a.m., Resident #49's clinical record was reviewed. A 3.0 Minimum Data Set Assessment, completed on 11/24/10, was on		of the Electronic Storage of MDS (Minimum Data Set) policy. · Facility practice has been revised so that completed 3.0 Minimum Data Set Assessments will be printed and placed on all residents' clinical records and made accessible to all professional staff members. · MDS staff and other professional staff will be educated on the revised facility practice. **How the corrective action (s)will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A CQI tool will be utilized by MDS Coordinator/designee to monitor compliance with printing and making accessible completed 3.0 MinimumData Set Assessments weekly x 4 weeks, monthly x2 months and quarterly thereafter. · Results of the audit will be presented to the CQI Committee monthly to ensure compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action.	

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	155757	A. BUILDING _____ B. WING _____	02/25/2011

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	the record. The Administrator was interviewed on 2/22/11 at 9:45 a.m. The Administrator indicated the completed assessments had not been maintained on the chart prior to the day before when all assessments were printed and placed on the clinical records by facility choice. The Administrator indicated Section A [Identification Information], Section V [Care Area Assessment (CAA) Summary, and Section Z [Assessment Administration] had been placed on the clinical record but Sections B [Hearing, Speech, and Vision,] Section C [Cognitive Patterns], Section D [Mood], Section E [Behavior], Section F [Preferences for			

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	Customary Routine and Activities], Section G [Functional Status], Section H [Bladder and Bowel], Section I [Active Diagnoses], Section J [Health Conditions], Section K [Swallowing/Nutritional Status], Section L [Oral/Dental Status] Section M [Skin Conditions], Section N [Medications], Section O [Special Treatments, Procedures, and Programs,] Section P [Restraints], Section Q [Participation in Assessment and Goal Setting], had not until after discussion with surveyors. 15. On 2/25/11 at 10:45 a.m., Resident #36's clinical record was reviewed. A 3.0 Minimum Data Set Assessment, completed on 1/7/11, was on the record.			

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	The Administrator was interviewed on 2/22/11 at 9:45 a.m. The Administrator indicated the completed assessments had not been maintained on the chart prior to the day before when all assessments were printed and placed on the clinical records by facility choice. The Administrator indicated Section A [Identification Information], Section V [Care Area Assessment (CAA) Summary, and Section Z [Assessment Administration] had been placed on the clinical record but Sections B [Hearing, Speech, and Vision,] Section C [Cognitive Patterns], Section D [Mood], Section E [Behavior], Section F [Preferences for Customary Routine and Activities], Section G			

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	[Functional Status], Section H [Bladder and Bowel], Section I [Active Diagnoses], Section J [Health Conditions], Section K [Swallowing/Nutritional Status], Section L [Oral/Dental Status] Section M [Skin Conditions], Section N [Medications], Section O [Special Treatments, Procedures, and Programs,] Section P [Restraints], Section Q [Participation in Assessment and Goal Setting], had not until after discussion with surveyors. 16. On 2/25/11 at 12:40 p.m., Resident #45's clinical record was reviewed. A 3.0 Minimum Data Set Assessment, completed on 12/21/10, was on the record. The Administrator was interviewed on 2/22/11 at 9:45			

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	a.m. The Administrator indicated the completed assessments had not been maintained on the chart prior to the day before when all assessments were printed and placed on the clinical records by facility choice. The Administrator indicated Section A [Identification Information], Section V [Care Area Assessment (CAA) Summary, and Section Z [Assessment Administration] had been placed on the clinical record but Sections B [Hearing, Speech, and Vision,] Section C [Cognitive Patterns], Section D [Mood], Section E [Behavior], Section F [Preferences for Customary Routine and Activities], Section G [Functional Status], Section H [Bladder and Bowel], Section I			

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	[Active Diagnoses], Section J [Health Conditions], Section K [Swallowing/Nutritional Status], Section L [Oral/Dental Status] Section M [Skin Conditions], Section N [Medications], Section O [Special Treatments, Procedures, and Programs,] Section P [Restraints], Section Q [Participation in Assessment and Goal Setting], had not until after discussion with surveyors. 17. On 2/25/11 at 1:20 p.m., Resident #39's clinical record was reviewed. A 3.0 Minimum Data Set Assessment, completed on 12/17/10, was on the record. The Administrator was interviewed on 2/22/11 at 9:45 a.m. The Administrator indicated the completed			

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	assessments had not been maintained on the chart prior to the day before when all assessments were printed and placed on the clinical records by facility choice. The Administrator indicated Section A [Identification Information], Section V [Care Area Assessment (CAA) Summary, and Section Z [Assessment Administration] had been placed on the clinical record but Sections B [Hearing, Speech, and Vision,] Section C [Cognitive Patterns], Section D [Mood], Section E [Behavior], Section F [Preferences for Customary Routine and Activities], Section G [Functional Status], Section H [Bladder and Bowel], Section I [Active Diagnoses], Section J [Health Conditions], Section K			

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	[Swallowing/Nutritional Status], Section L [Oral/Dental Status] Section M [Skin Conditions], Section N [Medications], Section O [Special Treatments, Procedures, and Programs,] Section P [Restraints], Section Q [Participation in Assessment and Goal Setting], had not until after discussion with surveyors. **Review of current facility Policy and Procedure titled "Electronic Storage of MDS (Minimum Data Set)," dated 11/2010, on 2/21/11 at 3 p.m., indicated "MDS 3.0 item sets will be stored in electronic form within current software; MDS 3.0 items sets are accessible electronically by an individualized user name and password; MDS 3.0 item sets will be made accessible to staff (including consultants), State agencies (including surveyors), CMS, and others who are authorized by law and need to review the information in order to provide care to the resident; 15 months of MDS data will be available. If there is not 15 months of electronic data then the remainder of the applicable MDS assessments will be printed and stored in a binder separate of the chart."** **3.1-20(d)**			

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F0315 SS=E	3. On 2/21/11 at 11:30 a.m. during initial tour, Resident #1 was observed to have a Foley catheter. On 2/24/11 at 11:30 a.m., Resident #1 was observed to be transferred by CNAs #11 and #12. When the resident was lifted from the wheelchair seat, the Foley catheter tubing was positioned under the resident's right leg. An indentation was observed on the resident's posterior right thigh. The CNAs placed the Foley catheter bag on the resident's abdomen (above the bladder level) during the transfer. The resident was provided incontinence care. The Foley catheter tubing was observed not to be secured the resident's leg to prevent catheter tubing movement and urethral erosion. Review of the clinical record of Resident #1 on 2/21/11 at 2:30 p.m. indicated a physician's order dated 12/10/10 on the February 2011 physician order sheet of Foley catheter care every shift and make sure secured to leg via strap. A current plan of care dated 12/22/10 was noted of resident requires an indwelling urinary catheter related to Neurogenic Bladder, and Paraplegic. 4. On 2/23/11 at 9:55 a.m., Resident #3 was observed to be in bed. The resident's Foley catheter tubing was observed to be	F0315	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #1 Foley catheter tubing was immediately secured to his leg. Resident's care plans were updated to reflect these needs. · Resident #3 no longer resides at the facility. · Resident #87 Foley catheter tubing was immediately secured to his leg. Resident's care plans were updated to reflect these needs. · Resident #36 was monitored by nursing staff with no signs or symptoms of infection noted. · Immediate training was completed to educate nursing staff on securing Foley catheter tubing and keeping catheter bags below the bladder level with transfers. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · Residents identified with Foley catheters will have the Foley catheter tubing secured at all times. · Residents identified with Foley catheters will have the catheter bag below bladder level with all transfers. · Residents requiring a change between Foley catheter bag and a Foley leg bag will have aseptic technique followed. **What measures will be put into place or what systemic changes you will make to ensure that the**	03/27/2011

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	placed over the siderail of the resident's bed. On 2/23/11 at 3:20 p.m., Resident #3 was observed to receive Foley catheter care by CNAs #6 and #7. The resident's Foley catheter was observed not to be secured to the resident's leg to prevent catheter tubing movement and urethral erosion. The resident was turned during the incontinence care to his side and the catheter tubing was observed to be pulled taut. On 2/24/11 at 1:30 p.m., Resident #1 was observed to be transferred from the wheelchair to bed utilizing the mechanical lift by CNAs #11 and #12. During the transfer, the Foley catheter bag full with urine was observed to be placed on the resident's abdomen (above the level of the resident's bladder). The Foley catheter tubing was observed not to be secured to the resident's leg. Review of the clinical record of Resident #3 on 2/24/11 at 3:35 p.m. indicated a physician's order of "please anchor Foley while IV hydration occurring. " Interview of the Director of Nursing Services on 2/25/11 at 11 a.m. indicated Foley catheter bags and tubing should be maintained below the bladder level and secured to prevent trauma. However, information not contained in the current policy and procedure or the skills training		**deficient practice does not recur?** · Residents with new physician orders for Foley catheters will have the Foley catheter tubing secured and maintained below bladder level with transfers. · Nursing staff will be educated on Foley catheter care including aseptic technique and maintenance. **How the corrective action (s)will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A CQI tool will be utilized by Nurse Managers to monitor compliance with securing Foley catheter tubing and keeping catheter bags below bladder level with transfers related to residents with Foley catheters weekly x 4 weeks, monthly x2 months and quarterly thereafter. · Results of the audit will be presented to the CQI Committee monthly to ensure compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action.	

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Review of the facility current policy and procedure titled "Foley catheter care and Maintenance" dated 1/2010, on 2/25/11 at 11 a.m., indicated "...Procedure for providing catheter care...8. Prevent from pulling on catheter as much as possible during this procedure..."

3.1-41(a)(2)

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F0315 SS=E	Based on observation, interview and record review, the facility failed to maintain urinary drainage catheters in a manner to prevent urinary tract infections for 4 of 4 residents reviewed in a sample of 24 with indwelling catheters in that drainage bags were not maintained below bladder level, catheters were not secured to prevent urethral irritation, and handwashing was not maintained during disconnection of leg bag and initiation of bladder irrigation to prevent contamination. [Residents #87, #36, #1, #3] Findings include: 1. During initial tour on 2/21/11 which began at 11:15 a.m., with the Assistant Director of Nursing [ADNS]	F0315	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #1 Foley catheter tubing was immediately secured to his leg. Resident's care plans were updated to reflect these needs. · Resident #3 no longer resides at the facility. · Resident #87 Foley catheter tubing was immediately secured to his leg. Resident's care plans were updated to reflect these needs. · Resident #36 was monitored by nursing staff with no signs or symptoms of infection noted. · Immediate training was completed to educate nursing staff on securing Foley catheter tubing and keeping catheter bags below the bladder level with transfers. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · Residents identified with Foley catheters will have the Foley catheter tubing secured at all times. · Residents identified with Foley catheters will have the catheter bag below bladder level with all transfers. · Residents requiring a change between Foley catheter bag and a Foley leg bag will have aseptic technique followed. **What measures will be put into place or what systemic changes you will make to ensure that the**	03/27/2011

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	Resident #87 was identified as utilizing an indwelling Foley catheter. On 2/22/11 at 11:25 a.m., CNAs #2 was observed to provide pericare to Resident #87 and LPN #1 was observed to provide a treatment to the resident's coccyx area. The resident was turned back and forth during the care. The Foley catheter was observed not to be attached to prevent tension and irritation to the urethra during the care. On 2/24/11 at 3:10 p.m., CNAs #17 and #18 were observed to transfer Resident #87 from the wheelchair to bed with a mechanical lift. During the transfer, the CNAs were observed to handle the urinary drainage bag, raise it over the		**deficient practice does not recur?** · Residents with new physician orders for Foley catheters will have the Foley catheter tubing secured and maintained below bladder level with transfers. · Nursing staff will be educated on Foley catheter care including aseptic technique and maintenance. **How the corrective action (s)will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A CQI tool will be utilized by Nurse Managers to monitor compliance with securing Foley catheter tubing and keeping catheter bags below bladder level with transfers related to residents with Foley catheters weekly x 4 weeks, monthly x2 months and quarterly thereafter. · Results of the audit will be presented to the CQI Committee monthly to ensure compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action.	

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	resident's head during the transfer, and after positioning the resident in bed, laid the drainage bag on top of the mattress while removing the lift sling from underneath the resident. The Resident was turned back and forth during the procedure, and the catheter was observed not to be secured to prevent tension and irritation to the urethra. 2. During initial tour with RN #1 on 2/21/11 at 11:05 a.m., Resident #36 was identified as utilizing an indwelling Foley catheter and leg bag with an as needed continuous bladder irrigation. On 2/25/11 at 12:00 p.m., RN #16 was observed to disconnect Resident #36's leg bag from the Foley catheter, attach a regular			

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	urinary drainage bag, and attach a continuous bladder irrigation tubing to the Foley catheter. RN #16 put on a clean pair of gloves, moved the bladder irrigation pole from one side of the bed to the other. With the same gloves on RN #16 disconnected the leg bag, swabbed the catheter with an alcohol pad, attached a new drainage bag, cleansed the end of the flush tubing with an alcohol pad with same gloves on, changed the left glove and opened the roller clamp to the irrigation tubing with the right hand.			

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F0323 SS=E	Based on observation, interview, and record review, the facility failed to ensure a safe environment in that 4 of 4 residents in a sample of 24 [Residents #87, #1, #3, # 133] were observed not to be transferred with mechanical lifts in accordance with manufacturers' directions; 1 of 1 dependent resident on an air alternating mattress, was observed with parts of the body extending over the edge of the mattress in a sample of 24; and 22 of 34 residents of the memory care unit were observed in the dining/activity area unsupervised with a hot pot of coffee, a hot plate and toaster accessible to residents on the counter. Findings include:	F0323	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Immediate training was completed to educate nursing staff on proper transfers with mechanical lifts in accordance with manufacturer's guidelines. · Resident #87 was immediately repositioned in bed with one-quarter side rails in raised position. · The coffee pot, hot plate and toaster were removed from resident accessible areas in the Memory Care activity/diningroom. · Resident #87, 1, 3, and 133 showed no injuries or signs/symptoms of psychosocial distress after mechanical lift transfers. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents currently being transferred using the Invacare Reliant 450 or the Lumex LFI1050 Patient Lift have been identified. Nursing staff have been in-serviced on the proper use of mechanical lifts in accordance with the manufacturer's guidelines. · Residents who are coded as dependent have been identified and observed for proper bed positioning. All nursing and licensed staff have been in-serviced on the importance of	03/27/2011

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	1. During initial tour on 2/21/11 at 11:45 a.m., with the Assistant Director of Nursing Services [ADNS] Resident #87 was observed on an air alternating mattress, with two one quarter siderails in the lowered position. The head of the resident's bed was elevated 45 degrees, with a tube feeding infusing through a feeding tube. The ADNS identified the resident as having quadriplegia, traumatic brain injury, a continuous tube feeding and tracheostomy, and open area on the coccyx. On 2/22/11 at 11:25 a.m., the ADNS and CNAs #2 were observed to position Resident #87 on his left side to provide peri-care. The resident was observed to be on the edge of the air alternating mattress and		proper bed positioning and safety. · Safety assessments of all resident dining areas have been done. All potential burn hazards have been removed from areas accessible to residents. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Skills validations will be conducted for all CNA staff on usage of mechanical lifts including compliance with manufacturer's guidelines. · Skills validations will be conducted for all CNA staff on dependent resident bed positioning including safe body alignment. · Nursing staff orientation will include skills validations for the proper usage of mechanical lifts (including manufacturer's guidelines) and dependent resident bed positioning. · Hot coffee pot and warmer will be replaced by dietary department. Coffee will be provided to memory care residents in carafes. Toaster in memory care dining room has been secured in employee only area and utilized in secured area when needed. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A CQI audit tool will be utilized to monitor compliance with proper usage of mechanical lifts.	

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	for his legs, with splints on, to be extended over the edge of the bed during the care. After completion of the ADL [activities of daily living] care LPN #4 was observed to provide a dressing change to the resident's coccyx. Prior to the dressing change, LPN #4 attempted to scoot the resident back a little to avoid being so close to the edge of the bed. On 2/23/11 at 10:45 a.m., Resident #87 was observed in bed on the air alternating mattress. Two one-quarter siderails were observed on the bed in the lowered position. The resident's head of bed was elevated 45 degrees, and the pillow, and left shoulder were on the edge of the bed and extended over the edge of the mattress.		Resident transfers using mechanical lifts will be observed weekly X 4 weeks, monthly X 2 months and quarterly thereafter. · A CQI audit tool will be utilized to monitor compliance with proper bed positioning of dependent residents. Resident observations will be completed weekly X 4 weeks, monthly X 2 months and quarterly thereafter. · A CQI audit tool will be utilized to monitor compliance with resident safety in the Memory Care unit. Dining room observations will be done weekly X 4 weeks, monthly X 2 months and quarterly thereafter. · Results of these evaluation processes will be presented to the CQI Committee monthly to review for compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action.	

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	Resident #87's clinical record was reviewed on 2/21/11 at 1:45 p.m. The resident's diagnosis included, but was not limited to, quadriplegia. A Minimum Data Set [MDS] assessment, completed on 6/21/10, coded the resident as required total assistance of two for bed mobility. The assessment indicated bed rails were utilized for mobility. A plan of care dated 6/21/10 addressed the problem of needs bedrails to prevent injury from involuntary movements, storming, increased tone to left side, decorticate positioning/posturing. Interventions included but were not limited to, side rails per order, has specialty mattress.			

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	A side rail notification was noted for one-quarter side rails to be in side rail position, with physician's order dated 6/7/10. A side rail assessment, completed on 1/21/11 indicated the use of siderails provides tactile bed boundaries with sensory deficits or poor muscle coordination to prevent accidental rollouts. Manufacturer directions for the Stage IV Lateral Support air alternating mattress, provided by the DON on 2/24/11 at 2:50 p.m., included, but was not limited to, "3.4 FirmForm Edge. The FirmForm Edge for the Stage IV Lateral Support (LS) is engineered to not deform or compress under pressure. The FirmForm Edge helps maintain stable support at			

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	the critical safety area of the mattress, between the edge of the bed and the siderails, dramatically reducing the risk of patient falls and entrapment." 2. On 2/25/11 at 12:35 p.m. on the memory care unit, 22 of 34 residents of the unit were observed in the dining/activity room without staff supervision. A coffee maker was observed on the counter area of the unit, accessible to the residents, with a full pot of hot coffee on. A hot plate and toaster were also observed on the counter plugged in and operational when switched on. A housekeeper was observed at the opposite end of the room with her back to the residents sweeping. Nursing staff were not observed in the room.			

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	The Unit Manager, RN #19, was interviewed on 2/25/11 at 12:40 p.m. The RN indicated the coffee carafe is usually filled after lunch to be available for residents. The RN indicated there are times when staff are not in the room and she could not say that no resident might try to pour self a cup of coffee. 3. On 2/24/11 at 3:10 p.m., CNAs #17 and #18 were observed to transfer Resident #87 from the wheelchair to bed with the Invacare 450 mechanical lift. The mechanical lift was positioned from the side of the resident's chair. After attaching the sling to the lift, the resident was raised over the arms of the			

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	chair, and the CNAs continued to raise the resident higher. The resident's head was observed to be higher than the CNAs. While perpendicular to the lift mast, the resident was transferred from the wheelchair to the bed in the elevated position. The base of the lift was closed and positioned under the bed, while the resident was lowered into the bed. Resident #87's clinical record was reviewed on 2/21/11 at 1:45 p.m. The resident's diagnosis included, but was not limited to, quadriplegia. A Minimum Data Set [MDS] assessment completed on 6/21/10, coded the resident as non-ambulatory, required total assistance of two for bed mobility and transfers. The			

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	assessment coded the resident as utilizing a mechanical lift. A plan of care, dated 6/21/10, addressed the problem of at risk for falls related to Hoyer lift for transfers, loss of range of motion, stiffness, muscle spasms, and medication regimen. An approach included but was not limited to, Hoyer lift for transfers (staff assist of 2).			

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F0323 SS=E	4. On 2/24/11 at 12 p.m., Resident #1 was observed to be transferred utilizing the "Invacare Reliant 450 " Hoyer lift by CNAs #11 and #12. The resident was transferred from the wheelchair to the bed. During the transfer, the base of the lift was open when lifted and the CNAs closed the base of the lift after pulled away from the wheelchair. The resident was raised 18 inches of the wheelchair seat and remained at the high height. The base of the lift remained in the closed position when transported to the bed and when the resident was lowered into the bed. Incontinence care was provided to the resident. The resident was then transferred back into the wheelchair with the Hoyer lift. The CNAs lifted the resident 18 inches off of the bed and the base of the lift was closed when lifted. The base remained closed when transported and then open when in front of the wheelchair. The resident was then lowered into the seat of the wheelchair. Review of the clinical record of Resident #1 on 2/21/11 at 2:30 p.m. indicated a physician's order dated 12/11/10 of Hoyer lift to transport related to increased pain and immobility. 5. On 2/24/11 at 1:30 p.m., Resident # 3 was observed to be transferred from the	F0323	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Immediate training was completed to educate nursing staff on proper transfers with mechanical lifts in accordance with manufacturer's guidelines. · Resident #87 was immediately repositioned in bed with one-quarter side rails in raised position. · The coffee pot, hot plate and toaster were removed from resident accessible areas in the Memory Care activity/diningroom. · Resident #87, 1, 3, and 133 showed no injuries or signs/symptoms of psychosocial distress after mechanical lift transfers. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents currently being transferred using the Invacare Reliant 450 or the Lumex LFI1050 Patient Lift have been identified. Nursing staff have been in-serviced on the proper use of mechanical lifts in accordance with the manufacturer's guidelines. · Residents who are coded as dependent have been identified and observed for proper bed positioning. All nursing and licensed staff have been in-serviced on the importance of	03/27/2011

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	wheelchair to the bed utilizing the "Invacare Reliant 450" Hoyer lift by CNAs #11 and #12. The resident was lifted off of the wheelchair seat 15 inches. The resident remained at the same high height during the transfer. The base of the lift was opened when lifted and remained open until reaching the bed. The base was then closed to go under the bed and then only opened slightly when under the bed. The resident was lowered with the base only opened slightly. Review of the clinical record on 2/24/11 at 3:35 p.m. indicated a physician's order dated 2/23/11 of resident up in the wheelchair per Hoyer lift at least one hour -two hours to receive therapy. Review of the manufacturer's guidelines for the "Invacare" Hoyer lift, on 2/25/11 at 11:15 a.m., indicated "...LIFTING THE PATIENT: ...The legs of the lift must be in the maximum open position and the shifter handle locked in place for optimum stability and safety. If it is necessary to close the legs of the lift to maneuver the lift under a bed, close the legs of the lift only as long as it takes to position the lift over the patient and lift the patient off the surface of the bed. When the legs of the lift are no longer under the bed, return the legs of the lift to		proper bed positioning and safety. · Safety assessments of all resident dining areas have been done. All potential burn hazards have been removed from areas accessible to residents. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Skills validations will be conducted for all CNA staff on usage of mechanical lifts including compliance with manufacturer's guidelines. · Skills validations will be conducted for all CNA staff on dependent resident bed positioning including safe body alignment. · Nursing staff orientation will include skills validations for the proper usage of mechanical lifts (including manufacturer's guidelines) and dependent resident bed positioning. · Hot coffee pot and warmer will be replaced by dietary department. Coffee will be provided to memory care residents in carafes. Toaster in memory care dining room has been secured in employee only area and utilized in secured area when needed. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A CQI audit tool will be utilized to monitor compliance with proper usage of mechanical lifts.	

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	the maximum open position and lock the shifter handle immediately...Lifting/Moving the Patient....1. Pump the lift handle or press the UP button to raise the patient above the bed. The patient should be elevated high enough to clear the bed with their weight fully supported by the lift...3. When the patient is clear of the bed surface, swing their feet off the bed...5. When moving the patient away from the bed, turn the patient so that he/she faces assistant operating the patient lift. 6. Press the DOWN button...lowering the patient so that his feet rest on the base of the lift, straddling the mast... NOTE: The lower center of gravity provides stability making the patient feel more secure and the lift easier to move..."		Resident transfers using mechanical lifts will be observed weekly X 4 weeks, monthly X 2 months and quarterly thereafter. · A CQI audit tool will be utilized to monitor compliance with proper bed positioning of dependent residents. Resident observations will be completed weekly X 4 weeks, monthly X 2 months and quarterly thereafter. · A CQI audit tool will be utilized to monitor compliance with resident safety in the Memory Care unit. Dining room observations will be done weekly X 4 weeks, monthly X 2 months and quarterly thereafter. · Results of these evaluation processes will be presented to the CQI Committee monthly to review for compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action.	

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F0323 SS=E	6. On 2/24/11 at 12 noon, CNAs #'s 21 and 22 transferred resident #133 from a bed to a wheelchair. While using a "Lumex" mechanical lift the CNAs prior to lifting the resident from the bed locked the wheels of the lift. When lowering the resident into the wheelchair, the CNAs locked the wheels of the lift. The manufacturer's guidelines for the "Lumex LFI1050 Patient Lift" was provided on 2/25/11 at 10 a.m. Documentation indicated "Warning: Do not lock the brakes or block the wheels when lifting. The casters must be FREE to roll to allow the patient lift to stabilize itself when the patient is initially lifted from a chair, bed or any stationary object." 3.1-45(a)(1) 3.1-45(a)(2)	F0323	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Immediate training was completed to educate nursing staff on proper transfers with mechanical lifts in accordance with manufacturer's guidelines. · Resident #87 was immediately repositioned in bed with one-quarter side rails in raised position. · The coffee pot, hot plate and toaster were removed from resident accessible areas in the Memory Care activity/diningroom. · Resident #87, 1, 3, and 133 showed no injuries or signs/symptoms of psychosocial distress after mechanical lift transfers. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents currently being transferred using the Invacare Reliant 450 or the Lumex LFI1050 Patient Lift have been identified. Nursing staff have been in-serviced on the proper use of mechanical lifts in accordance with the manufacturer's guidelines. · Residents who are coded as dependent have been identified and observed for proper bed positioning. All nursing and licensed staff have been in-serviced on the importance of	03/27/2011

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			proper bed positioning and safety. · Safety assessments of all resident dining areas have been done. All potential burn hazards have been removed from areas accessible to residents. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Skills validations will be conducted for all CNA staff on usage of mechanical lifts including compliance with manufacturer's guidelines. · Skills validations will be conducted for all CNA staff on dependent resident bed positioning including safe body alignment. · Nursing staff orientation will include skills validations for the proper usage of mechanical lifts (including manufacturer's guidelines) and dependent resident bed positioning. · Hot coffee pot and warmer will be replaced by dietary department. Coffee will be provided to memory care residents in carafes. Toaster in memory care dining room has been secured in employee only area and utilized in secured area when needed. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A CQI audit tool will be utilized to monitor compliance with proper usage of mechanical lifts.	

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			Resident transfers using mechanical lifts will be observed weekly X 4 weeks, monthly X 2 months and quarterly thereafter. · A CQI audit tool will be utilized to monitor compliance with proper bed positioning of dependent residents. Resident observations will be completed weekly X 4 weeks, monthly X 2 months and quarterly thereafter. · A CQI audit tool will be utilized to monitor compliance with resident safety in the Memory Care unit. Dining room observations will be done weekly X 4 weeks, monthly X 2 months and quarterly thereafter. · Results of these evaluation processes will be presented to the CQI Committee monthly to review for compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action.	

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F0332 SS=D	Based on observation, record review, and interview, the facility failed to ensure it was free of a medication error rate of greater than 5% for 3 of 5 residents in a supplemental sample of 5 (Resident #5, Resident #26, and Resident # 133) observed receiving medications. Three errors in medication were observed during 50 opportunities for error in medication administration. This resulted in a medication error rate of 6 %. Findings include: 1. On 2/24/11 at 2 p.m., LPN #14 was observed to administer medications to Resident #26. The nurse was observed to administer medications to Resident #26 which included but was not limited to Sinemet CR (controlled release) 50/200 milligram tablet. The tablet was crushed and provided to the resident in apple sauce. Review of the clinical record of Resident #26 on 2/25/11 at 10:25 a.m. indicated a physician's order dated 1/4/11 of Sinemet CR 50/200 milligram one tablet five times daily. Review of the facility's current policy and procedure titled "Medications that cannot be crushed:" [no date] on 2/24/11 at 3:40	F0332	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #26 receives medications per physician orders and administration of medication is given per standards of practice. · Resident #5 receives medications per physician orders and administration of medication is given per standards of practice. · Resident # 133 (should be #116) receives medications per physician orders and administration of insulin is given with food. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have been identified who have physician orders for medications that cannot be crushed and that require administration of insulin with food. · The physician will be notified for those residents identified with medications that cannot be crushed to request therapeutic interchanges. · New residents and existing residents with new physician orders for Do Not Crush medications have the potential to be affected. These residents will have physician orders reviewed by nurse management personnel Monday - Friday, excluding holidays, to identify physician orders for Do	03/27/2011

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	p.m. indicated "Generally, medications which should not be crushed fall into one of the following categories: Extended-release products. The formation of some tablets is specialized as to allow the medication within to slowly release into the body * Common abbreviations for Extended-release products: ...CR Controlled release..." Review of the 2010 "Nursing Spectrum Drug Handbook" on 2/25/11 at 10 a.m. indicated for Sinemet CR "patient teaching - Instruct patient to swallow extended -release tablets whole without crushing or chewing them..." 2. On 2/25/11 at 9:10 a.m., RN # 15 was observed to administer medications to Resident #5. The nurse was observed to administer medications to Resident #5 which included but was not limited to Dynacirc CR 10 mg tablet. The tablet was crushed and provided to the resident in apple sauce. Review of the clinical record of Resident #5 on 2/25/11 at 10: 25 a.m. indicated a physician's order dated 2/15/11 of Dynacirc CR 10 milligram everyday. Review of the facility's current policy and procedure titled "Medications that cannot		Not Crush medications. · Physician orders will be obtained for those residents indentified to have insulin requiring administration with food. · Licensed nurses will be re-educated on following physician orders by the Pharmacist and/or DNS. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Resident's receiving Do Not Crush Medications will have medication cards and MAR's labeled DO NOT Crush. · Pharmacist will conduct medication pass audits on three nurses monthly. · Licensed nurses will be educated on how to identify medications that are not to be crushed and insulin's that require administration with food. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A Physician Order/MAR CQI audit tool will be utilized to review appropriate identification of medications that cannot be crushed and insulin's that must be administered with food weekly x 4, monthly x2 months and quarterly thereafter. · Results of the audit will be presented to the CQI Committee monthly to ensure compliance and follow-up. Identified noncompliance may	

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	be crushed:" [no date] on 2/24/11 at 3:40 p.m. indicated "Generally, medications which should not be crushed fall into one of the following categories: Extended-release products. The formation of some tablets is specialized as to allow the medication within to slowly release into the body * Common abbreviations for Extended-release products: ...CR Controlled release..." Review of the 2010 "Nursing Spectrum Drug Handbook" on 2/25/11 at 10 a.m. indicated for DynaCirc CR "Administration - Don't crush or break controlled-release tablets. Make sure patient swallows them whole..."		result in staff re-education and/or disciplinary action.	

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F0332 SS=D	3. During initial tour on 2/21/11 which began at 11:30 a.m., with LPN #25, the LPN indicated resident #133 was not interviewable. On 2/24/11 at 1:20 p.m., LPN #23 administered 8 units of Novolog 100/ml Insulin to resident #133. The nurse did not offer the resident any food items and moved on to the next resident to administer medications. At 1:50 p.m., the resident was observed in the therapy department. The resident was questioned as to whether she had eaten anything since the insulin injection, the resident indicated she could not remember. Therapist #24 indicated the resident had been in the therapy room for the past 25 minutes and had not received any food or drinks while in therapy. During interview of LPN #23, on 2/24/11 at 2 p.m., the LPN indicated the resident had snacks in her room, but she was unsure if the resident had eaten anything since administering the Insulin. Information concerning "Novolog Insulin" was provided by the facility on 2/25/11 at	F0332	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #26 receives medications per physician orders and administration of medication is given per standards of practice. · Resident #5 receives medications per physician orders and administration of medication is given per standards of practice. · Resident # 133 (should be #116) receives medications per physician orders and administration of insulin is given with food. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have been identified who have physician orders for medications that cannot be crushed and that require administration of insulin with food. · The physician will be notified for those residents identified with medications that cannot be crushed to request therapeutic interchanges. · New residents and existing residents with new physician orders for Do Not Crush medications have the potential to be affected. These residents will have physician orders reviewed by nurse management personnel Monday - Friday, excluding holidays, to identify physician orders for Do	03/27/2011

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	10 a.m., indicated "You should eat a meal within 5 to 10 minutes of receiving Novolog to avoid low blood sugar." 3.1-25(b)(9) 3.1-48(c)(1)		Not Crush medications. · Physician orders will be obtained for those residents indentified to have insulin requiring administration with food. · Licensed nurses will be re-educated on following physician orders by the Pharmacist and/or DNS. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Resident's receiving Do Not Crush Medications will have medication cards and MAR's labeled DO NOT Crush. · Pharmacist will conduct medication pass audits on three nurses monthly. · Licensed nurses will be educated on how to identify medications that are not to be crushed and insulin's that require administration with food. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A Physician Order/MAR CQI audit tool will be utilized to review appropriate identification of medications that cannot be crushed and insulin's that must be administered with food weekly x 4, monthly x2 months and quarterly thereafter. · Results of the audit will be presented to the CQI Committee monthly to ensure compliance and follow-up. Identified noncompliance may	

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			result in staff re-education and/or disciplinary action.	

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F0441 SS=E	Based on observation, record review and interview, the facility failed to ensure glucose monitors were sanitized effectively and staff removed contaminated gloves, prior to touching other surfaces for 6 of 8 residents (Resident #133, Resident #36, Resident # 87, Resident #3, Resident #16, and Resident #1) observed receiving care and/or glucose monitoring in a sample of 24 and 1 of 1 resident (Resident 116) observed receiving glucose monitoring in supplemental sample of 5. Findings include: 1. On 2/24/11 at 1:10 p.m., LPN # 23 performed a blood sugar test on resident #116. Prior to performing the test, LPN #23 took a wet cloth from a container titled "Sani-Cloth HB Germicidal Disposable Wipe" and wiped the glucometer with the cloth. The nurse then took the glucometer in to the resident's room and performed a blood glucose test. The manufacturer's information for the product "Sani-Cloth HB" was provided by the Director of Nursing (DON) on 2/24/11 at 2:50 p.m. Documentation indicated, the contact time of the solution to remain on the glucometer, to kill certain blood borne pathogens should be 10 minutes.	F0441	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The blood glucose monitor for resident #116 was disinfected per manufacturer's guidelines. · Licensed nurses have been educated on the proper procedures for the use of the Sani-Cloth HB in regards to the contact time information noted in the manufacturer's guidelines. · Additional blood glucose monitors were made available on licensed nurses' medication carts to allow one blood glucose monitor to dry within specified time. · Residents' #1, #3, #16, #36, #87 and#133 were monitored by nursing staff with no signs or symptoms of infection noted. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have been identified that are currently receiving blood glucose monitoring. Nursing staff has been in-serviced on the recommended manufacturer guidelines of the use of the Sani-clothes used to clean blood glucose monitors. · All residents receiving perineal and/or Foley catheter care have been identified. Nursing staff has been in-serviced on proper infection control procedures during	03/27/2011

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	During interview of the DON, on 2/24/11, at 1:45 p.m., the DON indicated staff had been inserviced that contact time with the solution only had to be 30 seconds. The DON went on to indicate, the staff should have been inserviced to allow the glucometer to have contact with the solution for 10 minutes. 2. On 2/23/11 at 1 p.m., CNAs #8 provided peri-care for resident #133. The CNAs while wearing gloves, cleansed feces from the resident's buttocks and rectal area. While wearing the same gloves, the CNAs touched the resident's privacy curtain, removed a clear plastic bag from her pocket, open the bag to place soiled linens and touched the resident's shoulder.		perineal and Foley catheter care. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Blood glucose monitors are to be disinfected with a new Super Sani-Cloth with a contact time of 3 minutes or less. · Nursing staff will be educated on the proper procedures identified in the manufacturer's guidelines for use of the new Sani-Cloth. · Skills validations will be completed for all nursing staff for proper perineal and Foley catheter care. · All staff has been educated on infection control and hand washing procedure by DNS/designee. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A CQI monitoring tool will be utilized by DNS/designee to observe blood glucose monitor cleaning weekly X 4 weeks, monthly X 2 months and quarterly thereafter. · A CQI monitoring tool will be utilized by nurse management team to observe nursing staff perform resident care including perineal and Foley catheter care. Resident care observations will be conducted weekly X 4 weeks, monthly X 2 months and quarterly thereafter. · Infection Control results will be	

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			presented to the CQI committee monthly to review for compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action.	

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F0441 SS=E	3. During initial tour with RN #1 on 2/21/11 at 11:05 a.m., Resident #36 was identified as utilizing an indwelling Foley catheter and leg bag with an as needed continuous bladder irrigation. On 2/25/11 at 12:00 p.m., RN #16 was observed to disconnect Resident #36's leg bag from the Foley catheter, attach a regular urinary drainage bag, and attach a continuous bladder irrigation tubing to the Foley catheter. RN #16 put on a clean pair of gloves, moved the bladder irrigation pole from one side of the bed to the other. With the same gloves on RN #16 disconnected the leg bag, swabbed the catheter with an alcohol pad, attached a new drainage bag, cleansed the end of the flush tubing with an	F0441	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The blood glucose monitor for resident #116 was disinfected per manufacturer's guidelines. · Licensed nurses have been educated on the proper procedures for the use of the Sani-Cloth HB in regards to the contact time information noted in the manufacturer's guidelines. · Additional blood glucose monitors were made available on licensed nurses' medication carts to allow one blood glucose monitor to dry within specified time. · Residents' #1, #3, #16, #36, #87 and#133 were monitored by nursing staff with no signs or symptoms of infection noted. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have been identified that are currently receiving blood glucose monitoring. Nursing staff has been in-serviced on the recommended manufacturer guidelines of the use of the Sani-clothes used to clean blood glucose monitors. · All residents receiving perineal and/or Foley catheter care have been identified. Nursing staff has been in-serviced on proper infection control procedures during	03/27/2011

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	alcohol pad with same gloves on, changed the left glove and opened the roller clamp to the irrigation tubing with the right hand. 4. On 2/24/11 at 3:10 p.m., CNAs #17 and #18 were observed to transfer Resident #87 from the wheelchair to bed with a mechanical lift. While wearing gloves, the staff handled the Foley catheter tubing and with the same gloves on removed the lift sling from under the resident, and touched the lift before removing the gloves.		perineal and Foley catheter care. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Blood glucose monitors are to be disinfected with a new Super Sani-Cloth with a contact time of 3 minutes or less. · Nursing staff will be educated on the proper procedures identified in the manufacturer's guidelines for use of the new Sani-Cloth. · Skills validations will be completed for all nursing staff for proper perineal and Foley catheter care. · All staff has been educated on infection control and hand washing procedure by DNS/designee. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A CQI monitoring tool will be utilized by DNS/designee to observe blood glucose monitor cleaning weekly X 4 weeks, monthly X 2 months and quarterly thereafter. · A CQI monitoring tool will be utilized by nurse management team to observe nursing staff perform resident care including perineal and Foley catheter care. Resident care observations will be conducted weekly X 4 weeks, monthly X 2 months and quarterly thereafter. · Infection Control results will be	

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F0441 SS=E	5. On 2/23/11 at 3:20 p.m., Resident # 3 was observed to receive foley catheter care by CNAs #6 and #7. CNAs # 7, with gloves on, was observed to remove the resident's soiled brief. Without changing the contaminated gloves, CNAs #7 adjusted the resident's pillow. The CNAs then changed her gloves and provided foley catheter care for Resident #3. Without changing the contaminated gloves, the CNAs adjusted the resident's gown and bed linens. 6. On 2/24/11 at 11:30 a.m., CNAs #13 was observed to toilet Resident #16. The CNAs, with gloves on, removed the resident's brief soiled with bowel movement. The resident was observed to have a bowel movement while on the bedside commode. The CNAs with the same gloves on wiped the resident with toilet paper. Without changing the contaminated gloves, the CNAs turned off the pressure alarm sounding, pulled up the resident's pants, transferred the resident, removed the gait belt around the resident, and put the wheelchair legs back on the resident's wheelchair. 7. On 2/24/11 at 12 p.m., CNAs #11 and #12 were observed to transfer Resident #1 and provide incontinence care to the resident. Both CNAs were observed to	F0441	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The blood glucose monitor for resident #116 was disinfected per manufacturer's guidelines. · Licensed nurses have been educated on the proper procedures for the use of the Sani-Cloth HB in regards to the contact time information noted in the manufacturer's guidelines. · Additional blood glucose monitors were made available on licensed nurses' medication carts to allow one blood glucose monitor to dry within specified time. · Residents' #1, #3, #16, #36, #87 and#133 were monitored by nursing staff with no signs or symptoms of infection noted. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have been identified that are currently receiving blood glucose monitoring. Nursing staff has been in-serviced on the recommended manufacturer guidelines of the use of the Sani-clothes used to clean blood glucose monitors. · All residents receiving perineal and/or Foley catheter care have been identified. Nursing staff has been in-serviced on proper infection control procedures during	03/27/2011

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	handle the resident's foley catheter bag and tubing without wearing gloves and/or washing their hands after. After transferring Resident #1 with the hoyer lift, CNAs #11, with gloves on, was observed to again handle the resident's foley catheter bag and tubing. Without changing the contaminated gloves, the CNAs opened the resident's closet, removed the wash basin from closet, and moved the resident's wheelchair. Review of the facility's current policy and procedure titled "Infection Control - Procedures" [no date] on 2/25/11 at 10:55 a.m. indicated "...2. In brief, hands are washed: ...b. Before and after resident care procedures, c. After removing gloves and other protective equipment and before touching the next resident, d. Before touching a resident highly susceptible to infection, ...j. After handling soiled linen... " 3.1-18(l)		perineal and Foley catheter care. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Blood glucose monitors are to be disinfected with a new Super Sani-Cloth with a contact time of 3 minutes or less. · Nursing staff will be educated on the proper procedures identified in the manufacturer's guidelines for use of the new Sani-Cloth. · Skills validations will be completed for all nursing staff for proper perineal and Foley catheter care. · All staff has been educated on infection control and hand washing procedure by DNS/designee. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A CQI monitoring tool will be utilized by DNS/designee to observe blood glucose monitor cleaning weekly X 4 weeks, monthly X 2 months and quarterly thereafter. · A CQI monitoring tool will be utilized by nurse management team to observe nursing staff perform resident care including perineal and Foley catheter care. Resident care observations will be conducted weekly X 4 weeks, monthly X 2 months and quarterly thereafter. · Infection Control results will be	

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	155757	A. BUILDING _____ B. WING _____	02/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEGATE VILLAGE LLC	7510 ROSEGATE DR INDIANAPOLIS, IN46237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			presented to the CQI committee monthly to review for compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action.	